Public Health England

Protecting and improving the nation's health

Policy for Patients with No Recourse to Public Funds (NRPF) with have Multi Drug Resistant TB (MRD-TB)

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Public Health England
Wellington House
133-155 Waterloo Road
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

Prepared by: David Bagguley, Public Health Registrar
For queries relating to this document, please contact: renu.bindra@phe.gov.uk

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1. Purpose

1.1. The purpose of this policy is to:

- Provide background information on the increasing problem of multi-drug resistant TB in Yorkshire and Humber
- Summarise the current difficulties involved in providing support for patients with No Recourse to Public Funds (NRPF)
- Outline the benefits of adopting an agreed approach between stakeholders to improve the management of these patients in the community
- Describe possible patient pathways which could be adapted for local use

2. Definitions

2.1. Multi Drug Resistant TB

Multidrug-resistant TB (MDR-TB) is tuberculosis that does not respond to at least isoniazid and rifampicin, the 2 most powerful anti-TB drugs[1]. MDR-TB is much more difficult and expensive to treat than non-MDR TB, and patients may require long hospital stays with several months of intravenous medication. Treatment for MDR-TB can last up to two years, occasionally longer, compared with six months for standard TB[2].

2.2 No Recourse to Public Funds

Individuals who have no legal entitlement to financial support or assistance from the state are described as having No Recourse to Public Funds (NRPF). These are usually, but not always, migrants to the UK who are excluded from mainstream benefits and housing due to their immigration status.

[1] World Health Organisation (2018) *What is multidrug-resistant tuberculosis (MDR-TB) and how do we control it?* Available at http://www.who.int/features/qa/79/en/. Date accessed 28th February 2018.
[2] All Party Parliamentary Group on Global Tuberculosis. (2013) *Drug Resistant Tuberculosis: Old Disease - New Threat.* All Party Parliamentary Group on Global Tuberculosis: London.

3. Background and context of the policy

3.1 Epidemiology of TB in Yorkshire and Humber

3.1.1 Tuberculosis (TB) remains a national priority for action and whilst rates of TB are falling, the Yorkshire and Humber region has the third highest rate of TB in England and an above average proportion of cases of multi-drug resistant TB (MDR-TB).

3.1.2 The 2017 Annual Review of TB in Yorkshire and Humber, summarising data from 2015, reported an incidence rate of 8.2 per 100,000, which is not only a reduction on 2014 (9.6 per 100,000) but the lowest rate in the last 10 years[3].

3.1.3 However, the proportion of TB cases diagnosed with multi-drug resistant TB increased in 2015 from 2.5% in 2014 to 4% in 2015. Mono-resistance to Isoniazid increased from 8% in 2011 to 10% in 2015.

3.1.4 TB disproportionately affects underserved populations including ethnic minorities, refugees & asylum seekers, migrants, those with histories of imprisonment, homelessness or substance misuse and those who are immunocompromised.

3.1.5 Despite the overall reduction in TB cases, the number of cases in Yorkshire and Humber with social risk factors (homelessness, drug or alcohol misuse or imprisonment) has not declined in keeping with national picture.

3.1.6 In 2015, 11.7% of cases in Yorkshire and Humber had at least one social risk factor recorded (11.8% nationally). TB cases with social risk factors are more likely to have pulmonary disease and drug resistance, and have worse outcomes[4].

3.1.7 Of recorded MDR-TB cases in Yorkshire and Humber in 2015, approximately 30% of patients were born in Eastern Europe. This stands in contrast to the national picture where the Indian subcontinent accounted for the country of birth in the majority of cases.

3.2 Gaps in current national guidance

3.2.1 In recent years, Yorkshire and Humber has had a small number of MDR-TB cases which have proved extremely complex to manage and required significant

[3] Public Health England (2017) *Tuberculosis in Yorkshire and Humber: Annual review (2015 data)*
[4] Public Health England (2017) *Tuberculosis in Yorkshire and Humber: Annual review (2015 data)*

input from local TB teams, Local Authority, Public Health England and NHS Commissioners and Providers.

3.2.2 It is recognised that part of this complexity is due to the lack of national guidance which clarifies the specific financial obligations of commissioners in respect of providing housing and other support costs for patients with NRPF.

3.2.3 National Institute for Health and Care Excellence (NICE) guidance relating to MDR-TB sets out general obligations of commissioners in respect of supporting community treatment:

- "have the skills and resources necessary to manage the care of people with complex social and clinical needs" (1.8.7.1)
- "have access to funds through government and clinical commissioning groups that can be used flexibly to improve adherence to treatment amongst underserved groups" (1.8.7.1)
- "multidisciplinary TB teams, commissioners, local authority housing lead officers and other social landlords, providers of hostel accommodation, hospital discharge teams, Public Health England and the Local Government Association should work together to agree a process for identifying and providing accommodation for homeless people diagnosed with active pulmonary TB who are otherwise ineligible for state-funded accommodation…this includes people who are not sleeping rough but do not have access to housing or recourse to public funds" (1.8.11.2)
- "local government and clinical commissioning groups should fund accommodation for homeless people diagnosed with active TB who are otherwise ineligible for state-funded accommodation" (1.8.11.3)

3.2.4 Furthermore, in their guidance on reducing the health burden of TB, Public Health England recommends that Local Authorities "ensure commissioning of appropriate access to health and social care support to enable patients to complete treatment". In addition, Clinical Commissioning Groups are encouraged to "commission appropriate access to services, treatment and support to enable patients to complete treatment".

3.2.5 In view of the expectations of commissioners outlined in the NICE and National PHE guidance, PHE Yorkshire and Humber have undertaken some specific work related to MDR-TB and provision of treatment.

3.2.6 In 2016, a narrative report was compiled which collated case reports and clinician experiences associated with the treatment of complex cases. A number of common themes with significant implications on the ability of cases to complete treatment were identified, including the uncertainty surrounding the funding of support costs for Directly Observed Treatment (DOT) in the community and the potential impact this was having on patient care.

3.2.7 In 2017, an economic analysis of three cases of MDR-TB in patients with NRPF estimated the costs to the public sector associated with addressing these complex social circumstances. Costs associated with providing additional resource to support NRPF patients to receive and remain adherent with

treatment, were lower than the costs associated with situation management, i.e. costs incurred as a result of staff time and meeting space due to the need for multi-agency meetings, as well as legal services. A clear opportunity to reduce this type of cost, as well as improve the timeliness of care delivery was identified.

4. Aims and rationale of the policy

4.1 As discussed above, NICE guidance states that commissioners have a duty to work together to provide a solution in cases involving individuals with NRPF. Concerns over a lack of agreed approach and pathway have been recorded from clinicians working across the region in the narrative review from 2016. A 2017 economic analysis of past cases makes a clear argument for the adoption of agreements at local or sub-regional level to avoid the unnecessary situational management costs which can arise in these cases.

4.2 In 2017, an overview of the statutory guidance, lessons learnt from previous cases, and current approach to supporting treatment in NRPF patients, was presented to various partners, stakeholders and commissioners across Yorkshire and Humber. This included the regional Association of Directors of Public Health, Local Authorities, Quality and Steering Groups (whose members include CCGs, Voluntary Sector, and NHS England), and NHS Specialised Commissioning.

4.3 A broad consensus emerged through this engagement process that the lack of a clear funding mechanism to support NRPF patients has the potential following consequences:

- A heightened clinical risk due to possible non-adherence to treatment regimen
- Excessive costs of situational management over and above the costs associated with providing additional support to patients, which constitutes a poor use of public funds
- A drain on the energy and resilience of the regional workforce (across multiple organisations)
- A significant detrimental impact on patient and family experience

4.4 There is therefore now a strong case for TB commissioners and other stakeholders to adopt a common approach to managing cases of MDR-TB for patients with NRPF. This is likely to be most effectively implemented with reference to an agreed common patient pathway.

4.5 Aims of the policy

4.5.1 The aims of adopting such a patient pathway between organisations are as follows:

- To ensure that a patient with MDR-TB who has NRPF will be accommodated for the duration of their treatment, and be able to access support costs (for subsistence, travel, etc.)
- To improve the health of a patient due to the provision of a safe and supported home environment
- To minimise transmission of MDR-TB in the community due to adherence to and completion of treatment

- To reduce the risk of development of further drug resistance
- To improve overall outcomes for the TB service and improve the quality of care provided
- To reduce the avoidable situational management typically associated with MDR-TB cases in patients with NRPF
- To improve partnership working within local TB systems and prevent unnecessary duplication of workload
- To satisfy NICE recommendations as per the national Tuberculosis guidance (NG33)
- To provide system assurance that an agreed plan is in place in order to mitigate the potential costs associated with MDR-TB in NRPF cases

4.6 Summary of potential options to address MDR-TB in NRPF

4.6.1 The advantages and disadvantages of adopting the proposed approach in this policy or continuing with current arrangements are outlined below.

4.6.2 Option 1: No action - Advantages

- No further input required by partners
- Changes to organisations and budgets over time may suit treating such cases on a case-by-case basis
- Workforce gain an understanding of issues involved in responding to cases, e.g. eligibility for housing support

4.6.3 Option 1: No action – Disadvantages

- Current arrangements create uncertainty and inconsistency between cases
- Current arrangements mean that funding is inefficient, unreliable and has the potential to lead to poor patient care due to the time required for commissioners to agree to a individualised funding plan
- Potential for increased inpatient costs due to potentially avoidable delays in provision of community accommodation
- Opportunity costs across the system are significant particularly when compared to actual costs incurred in providing support
- Inefficient use of staff resources, e.g. clinical staff having to manage non-healthcare needs, leading to decreased capacity and resilience

4.6.4 Option 2: Local patient pathway by LA or CCG area - Advantages

- An agreed pathway (potentially backed by a Memorandum of Understanding) will clearly define roles and responsibilities of system commissioners, helping to speed up and optimise the management of NRPF cases
- A more streamlined, efficient process has the potential to reduce inpatient costs (by allowing timely discharge to community), as well as situational management costs associated with these cases
- The quality of care a patient receives is likely to be improved due to resource being available in a timely manner, which will help to bolster patient dignity and respect

- Likely improvement in patient adherence to treatment and reduce the risk of loss to follow up
- Decreased risk of the development of further drug resistance
- Creates a process which is consistent with NICE and national PHE guidance

4.6.5 Option 2: Local patient pathway by LA or CCG area – Disadvantages

- GPs who register homeless patients and asylum seekers may be at a financial disadvantage
- All organisations with a role in management of NRPF patients have to agree a common pathway

5. Operational considerations

5.1 Defining NRPF: Statutory legislation surrounding NRPF status

5.1.1 Local authorities are restricted by legislation with regard to what it can provide in terms of assistance and support for all group of people who have NRPF.

5.1.2 Section 21 of the Care Act 2014 states that a local authority may not meet the needs for care and support of an adult or carer to whom section 115 (Exclusion from benefits) of the Immigration and Asylum Act 1999 applies and whose needs for care and support have arisen solely:

- Because they are destitute; or
- Because of the physical effects, or anticipated physical effects of being destitute.

5.1.3 A person is destitute if:

- S/He does not have adequate accommodation or any means of obtaining it; or
- S/He has adequate accommodation or the means of obtaining it, but cannot meet his/her other essential living needs

5.1.4 Section 115 of the Immigration and Asylum Act 1999 applies to someone who is not a national of an EEA state and who:

- Requires leave to enter or remain in the United Kingdom (UK) and does not have it
- Has leave to enter or remain in the UK which is subject to a condition that s/he has NRPF
- Has leave to enter or remain in the UK given as a result of a maintenance undertaking (for example, adult dependant relatives of people with settled status)
- Has leave to enter or remain in the UK only until a pending appeal has been heard

5.1.5 Schedule 3 of the Nationality, Immigration and Asylum Act 2002 states that the following five groups are ineligible for support and assistance under the Care Act 2014:

- Individuals granted refugee status by another EEA state
- EEA nationals and their dependants
- Failed asylum seekers who fail to comply with removal directions
- Individuals unlawfully present in the UK (e.g. people who have overstayed their visas, illegal entrants, refused asylum seekers)
- Failed asylum seekers with dependent children who have been certified by the Secretary of State as having failed to take steps to leave the county voluntarily

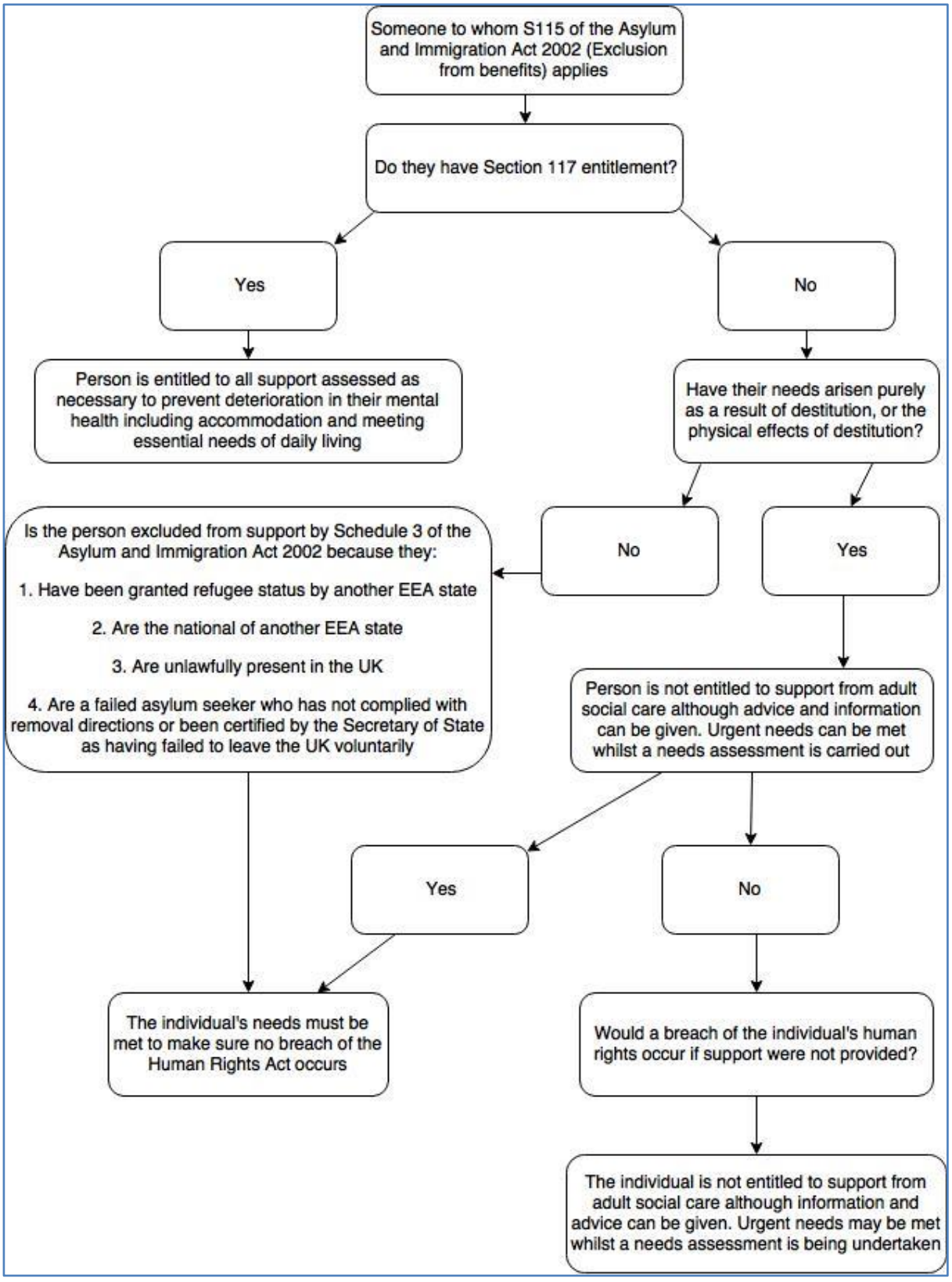
5.1.6 These restrictions are, however, subject to the overriding obligation upon local authorities to respect an individual's human rights and perform their duties in a way which does not constitute a breach of those rights.

5.1.7 If it appears that to withhold support could create such a breach, the local authority must undertake a Human Rights Assessment to consider whether the bar on providing support under the Care Act 2014 should be lifted.

5.1.8 Following the judgment in Limbuela v Secretary of State (2004), refusing to provide accommodation to an adult whilst the relevant assessments are being undertaken, when this is needed to prevent homelessness, is deemed to breach an individual's right to be free from inhumane treatment (Article 3 of ECHR). In these circumstances, local authorities should normally provide care and support to meet an individual's urgent needs until a needs assessment can be undertaken.

5.1.8 For the above groups of people, local authorities are not prevented from providing information and advice.

5.2 Suggested pathway for determining whether a patient is NRPF



5.3 Suggested pathway for management of NRPF cases

Process	Responsible team
1. Establish eligibility for state funding in order to confirm the patient is NRPF • What is the immigration status of the patient?	Local Authority (Welfare Benefits Advice / Adult Social Care)
2. Identify patients' local connections, including: • Last known address • Whether they are registered with a GP • Where any family are located • Street where individual was habitually rough sleeping Inform HPT of this information.	TB Case Manager
3. Conduct a needs assessment • Does the individual meet the criteria for housing under the Care Act? • Are they subject to Schedule 3 of the Nationality, Immigration and Asylum Act 2002?	Local Authority Adult Social Care team
4. Conduct Human Rights Assessment • Would not providing support be a breach of individual's human rights?	Local Authority Adult Social Care team
5. Conduct Mental Health Assessment • Is the individual entitled to accommodation and support under Section 117?	TB Case Manager
6. If patient is NRPF and not eligible for support, arrange a case conference	TB Case Manager